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A RAND NOTE

Multiple Employer Welfare Arrangements

Arleen Leibowitz, Cheryl Damberg,
Kathleen Eyre

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Prepared for the
U.S. Department of Labor

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PREFACE

This Note describes the market for health insurance—particularly multiple employer welfare arrangements (MEWAs)—for small firms. First, the general characteristics of this market are examined, then the types of MEWAs are described. A third section summarizes information on state regulation of MEWAs. This Note should interest researchers and policymakers concerned with alternative ways to provide health care coverage to employees of small firms.

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SUMMARY

Multiple employer welfare arrangements, or MEWAs, provide health benefits to employees of two or more firms at lower cost than that of conventional insurers. MEWAs are designed to give small firms access to health coverage on terms similar to those available to large firms by avoiding costly state regulation of insurance.

Although MEWAs have been touted as a low cost, equitable source of health coverage for small firms, in recent years they have become widely known to create insolvencies that have left numerous employers and employees liable for millions of dollars in unpaid health claims. To better understand MEWAs' place in the health insurance market, this report analyzes the dynamics of the small group insurance market, describes the alternative forms of MEWAs, and summarizes state regulation of MEWAs.

SMALL GROUP INSURANCE MARKETS

Small businesses face an increasingly costly and segmented market for health insurance. The cost of health insurance has been rising at double the general inflation rate over the last decade. Small firms, which generally operate on smaller profit margins than large firms, have been particularly hard hit by these increases in medical insurance costs.

Large firms have aggressively sought to control their health insurance outlays by negotiating more favorable prices with insurers or preferred provider organizations (PPOs) and by passing a growing share of the costs on to workers. Also, large firms have begun to self-fund their health insurance plans to avoid the added costs of state regulation.

Small firms do not have the same options for controlling costs for several reasons. They generally employ low wage workers who are less able to absorb cost increases. Without the market power of large businesses, small firms cannot negotiate favorable terms with PPOs and insurers. Furthermore, because of their size, they are unable to self-insure as a way to reduce plan costs.

Small firms also face higher costs for the same health insurance coverage purchased by larger firms. They are charged higher loading fees because of increased administrative and sales costs and greater risk premiums. In addition, purchased insurance carries the cost burden of premium taxes and reserve requirements. Most small firms find health insurance costs high; some may find insurance unavailable at any price, because of medical underwriting or industry exclusions that effectively eliminate particular types of occupations from coverage.

It is clear that there is a demand for health insurance by employees of small businesses and that price is a limiting factor. MEWAs have grown to meet this need. The fact that MEWAs flourish indicates that this segment of the health insurance market is highly price sensitive.

MEWAs offer health coverage at a lower price both because they attempt to lower administrative costs and because they claim preemption from state insurance regulation. However, the lower cost is accompanied by a higher risk. MEWAs do not participate in state insurance guarantee funds and their lower or (nonexistent) reserve levels mean that the participant bears a greater share of the risk, a fact many participants are unaware of.

TYPES OF MEWAs

There are many types of MEWAs, ranging from legitimate association plans, which exist for reasons other than providing health coverage, to entrepreneur-initiated plans, which are designed to defraud. The legitimate association plans may be fully insured or self-funded, but other types are most often self-funded or only partially insured.

Our analysis suggests that the factors that make MEWAs attractive to price-sensitive buyers also contribute to their high failure rate. By providing coverage without adequate underwriting, MEWAs attract risks that were either refused insurance or quoted very high prices by conventional insurers. They knowingly accept high risk individuals and firms without pricing the coverage commensurate with the risk. Another factor we observed is that self-insured MEWAs often have stop-loss insurance whose attachment point is too high to cover a significant share of the losses in the event of a failure, leaving beneficiaries highly vulnerable to significant financial losses.

In recent years, both unions and employee leasing firms have become major providers of health coverage to workers. Both entities have much in common with MEWAs. Both cover employees of small firms and both claim exemption from state insurance regulation. Some unions have made available associate memberships, which carry the right to enroll in the union health plan. Such plans are exempt from state regulation. Employee leasing firms claim to be single employers whose health benefit plans should be overseen by the federal Employee Retirement Income Security Act (ERISA) rather than by state insurance regulation. The validity of this claim has not been fully tested.

STATE REGULATION OF MEWAs

Our interviews with state insurance commissions indicated that considerable confusion exists in the states about the relevant federal statutes regarding MEWAs. Most

states had no special legislation regarding fully insured MEWAs, which were believed to be adequately regulated by the state insurance statutes.

Many states treated uninsured MEWAs as unlicensed insurance companies. The only successful regulatory scheme that legalized uninsured MEWAs treated them like insuring entities, requiring reserving practices similar to those imposed on conventional insurers. Some states had less stringent requirements for uninsured MEWAs, requiring only that the MEWAs register or inform health plan purchasers of their uninsured status. These states continue to experience MEWA insolvencies.

POLICY IMPLICATIONS

MEWAs do appear to fill a niche in the market by providing lower cost health insurance to small firms. If these lower prices result from inadequate reserving practices or fraud, small firms ultimately pay a heavy price for what appears to be lower cost health care coverage. However, the marketing success of MEWAs suggests that there is a market among small firms for legitimately lower priced health coverage. The analysis of state regulation indicates that MEWAs can be financially stable when they are subject to reserving requirements and premium taxes similar to those imposed on insurance companies.

Policymakers are now deciding how to make lower cost health coverage available to all workers. Requiring MEWAs to operate under constraints similar to those faced by conventional insurance companies and eliminating state mandate requirements for state-regulated insurers are two alternatives for achieving this goal.

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1. INTRODUCTION

In recent years, small firms facing difficulties in purchasing health coverage for their employees have turned to a new source—the multiple employer welfare arrangement, or MEWA. The MEWA is designed to allow small employers to gain access to health coverage on terms similar to those available to large firms by combining many employer groups.

MEWAs claim to have a price advantage over many individual policies for small firms because of their ability to pool the coverage needs of many employers. In addition, some MEWAs claim that they are employee welfare plans under the Employee Retirement Income Security Act (ERISA), and that therefore they are exempt from expensive state regulation of health insurance. MEWAs claim that these two advantages allow small firms to obtain some of the advantages available to large firms that self-fund their health insurance plans. In reality, all MEWAs are subject to state regulation and may not offer real pooling advantages as claimed.

MEWAs hold out the promise of a low cost, equitable source of health coverage for small firms. Most recently, however, MEWAs have captured the public's attention as a source of abusive business practices, resulting in insolvencies that have left employers and employees liable for millions of dollars in unpaid health claims. These insolvencies have hit employers and employees particularly hard because, unlike state-regulated insurance companies, policyholders under MEWAs may not have access to state insurance guarantee funds to cover unpaid claims.

Although there has been a great deal of concern about insolvent MEWAs, little is known about why MEWAs attract customers or how they operate. Nor is it known which characteristics of MEWAs are most closely associated with insolvency or what types of regulatory efforts have been most effective in preventing MEWA failures. This Note seeks to add to our knowledge of MEWAs by characterizing the different types of entities that operate as MEWAs, defining the climate in which MEWAs flourish, and describing how MEWAs operate.

The following section describes the recent trends in health insurance for small firms. These trends have provided fertile ground for the growth of MEWAs. The third section describes the different types of MEWAs and the way they operate. The fourth section draws on interviews with state insurance commissioners to characterize the various state regulatory environments in which MEWAs operate. The last section contains conclusions.

2. RECENT TRENDS IN HEALTH INSURANCE FOR SMALL FIRMS

Most American workers obtain health coverage through their employers. In 1986, 65 percent of the population under age 65 had employer-based health insurance, either as a benefit of their own employment or as the dependent of another covered worker (Piacentini and Cerino, 1990). Among working adults, three-quarters obtained health insurance coverage from their own employer.

Although most workers receive employer-based health coverage, large firms have been more likely to offer insurance to their workers than small ones. In an analysis of a random sample of U.S. firms in 1989, Sullivan, DiCarlo, and Lippert (1990) found that size was the most important predictor of whether a firm offered health insurance to its employees.

The disparity between large and small firms in the rates of health insurance coverage has become more pronounced in recent years. By 1989, only 26 percent of firms with fewer than 5 employees and 54 percent of firms with between 5 and 9 employees provided their employees with health insurance. The percentage of large firms (those with more than 100 employees) with employer-sponsored insurance has remained stable over time at 99 percent (Sullivan, DiCarlo, and Lippert, 1990).

Although large firms almost universally offer health insurance to some of their workers, not all employees who work in these firms have insurance. Part-time and seasonal workers are often excluded from insurance benefits (Marquis and Long, 1991). Nonetheless, employees in large firms are more likely to have health insurance as a job-related benefit than are employees of small firms. Whereas two-thirds of employees working in firms with 500 or more workers obtained health insurance through their own job, only 27 percent of workers in firms with fewer than 25 employees did so (Marquis and Long, 1991). Of course, many workers are insured as dependents on another person's policy. This is more likely for employees of small firms (24.5 percent) than for workers in large firms (13.7 percent).

Firms cite expensive premiums as the major reason for not offering health insurance coverage (Sullivan, DiCarlo, and Lippert, 1990). The rate of inflation in health insurance costs has exacerbated this problem in recent years. Between 1980 and 1987, business and individual contributions to health insurance premiums doubled, rising at an average annual rate of 11.7 percent (Levit, Freeland, and Waldo, 1989). Over the same interval, consumer prices rose 38 percent, or an average of 4.7 percent. Thus, health benefits have risen at more than twice the rate of general inflation. Because of this increase in costs, health insurance premiums have accounted for an increasing share of businesses' costs for total

compensation. Between 1980 and 1989, health benefits rose from 4.4 percent of the total compensation bill to 5.8 percent of compensation (Piacentini and Cerino, 1990).

Although both small and large firms have faced similar rates of increase in health insurance premiums (Gabel et al., 1989), small firms do not have the methods available to large firms to absorb such increases. These methods are described next, then we describe the unique features of the health insurance market for small firms. The final part of this section describes the role of MEWAs in the small group market.

METHODS USED BY LARGE FIRMS TO CONTROL HEALTH INSURANCE COSTS

Facing substantial increases in health insurance premiums, large firms have had some advantages over small firms in negotiating more reasonable insurance rates. First, the market power of many large firms has placed them in a stronger bargaining position. More important, however, large firms have begun increasingly to self-fund their health plans.

Self-funding allows a company to collect payments for health care costs and to pay benefits for medical expenses. The firm may rely on insurance only for stop-loss coverage, that is, coverage for claims over a specified level. In practice, much of the administration of these self-funded plans is carried out by third-party administrators (TPAs), many of which provide insurance to other firms (Battelle, 1981). Self-funding is believed to lower insurance costs because it eliminates the "middleman" and because it allows firms to bypass state regulation.

A firm that self-insures falls under the purview of ERISA rather than state insurance regulation (ERISA is discussed in greater detail in Sec. 3). For the current discussion of self-funded plans it is important to note that ERISA preempts and thus makes ineffective any state laws that relate to employee benefits. ERISA does not preempt state laws that regulate insurance, but prevents states from deeming a self-funded plan to be an insurance company. Thus, states can regulate purchased insurance contracts but not self-funded employer plans.

State regulation of insurance companies is designed to assure the purchasers of insurance that they are dealing with a financially stable company, but such regulation also adds to premium costs. For example, state insurance laws require that insurance companies establish reserves to assure payment of claims. Many states also impose premium taxes that support a guarantee fund, which would protect policyholders in the event a licensed insurer failed to pay claims. Self-funded plans neither pay premium taxes nor are eligible to use the guarantee fund.

A final financial advantage of self-funding over insurance contracts is that it allows a plan to offer a benefit package that does not meet the requirements of state mandates.

Reserves must be held in safe investments that typically yield a modest return. Higher reserve requirements reduce an insurer's income from investment of reserves and lead insurers to charge higher premiums. Many states currently require that all health insurance policies sold in their state cover particular sets of services (e.g., chiropractic). By requiring broader coverage of services than some policyholders may want, state mandates increase premium costs. One recent estimate suggests that the number of small businesses providing health insurance would be 16 percent greater in the absence of state mandates (Jensen and Gabel, 1989).

Larger firms have also had better access to managed health care plans. Some large firms have established their own preferred provider organizations (PPOs) as a way to control health care costs. Health maintenance organizations (HMOs) are another way to reduce health care expenses through capitation arrangements. Small firms have not uniformly had access to managed health care plans that may offer cost savings.

Finally, larger firms tend to employ more skilled workers, with higher earnings. Thus, they have been able to pass on a larger share of the increased health premium costs to their workers. Small firms that provide insurance are more likely than large firms to pay the entire premium cost (DiCarlo and Lippert, 1990). Profit margins in large firms are also higher, allowing these firms to absorb increases in health premiums more easily.

It is not clear how much additional health care expense even large firms can absorb, despite being better able than small firms to absorb increasing costs. Health care costs now account for an amount equivalent to total after-tax corporate profits (Levit and Cowan, 1990). The current trends are not sustainable.

HEALTH INSURANCE BARRIERS FACED BY SMALL FIRMS

Small firms are less able to pay the increasing costs of health coverage. First, their employees earn lower wages, on average, than those working in large firms. Thus, any given premium represents a larger percentage of employee compensation in small firms. Second, small firms tend to be labor intensive, so any percentage increase in health costs has a greater effect on costs. Third, small businesses have low profit margins and are unable to absorb the additional costs themselves.

Small firms also face higher premiums for a given amount of health insurance than do large firms. Above, we discussed the effects of reserve requirements, premium taxes, and state mandates on the cost of providing insurance, but there are additional factors that raise premiums for small firms. We begin our discussion of these factors with administrative and sales costs and factors related to risk management.

It is well known that insurers charge more to small firms than to large firms to provide a given amount of insurance. The amount that is charged over and above the expected payout on the insurance is called the loading fee, which reflects administrative costs and profits. Loading fees range from 5.5 percent of claims costs for the largest firms to up to 40 percent for the smallest firms (U.S. Library of Congress, 1988).

Insurers charge higher loading fees to small firms primarily because the cost of doing business with small firms is greater. Since it does not cost appreciably more to sell insurance to a firm with 100 employees than to a firm with 10 employees, the per capita sales costs are much higher for businesses with few workers. In addition, these small companies lack the personnel departments that could bear some of the administrative burden of monitoring enrollment, disenrollment, and claims questions. These management services must be provided by the insurer. In addition, insurers use costly medical underwriting for their small group clients. This issue will be discussed more fully below. Finally, insurers require a risk premium for dealing with small groups. To understand why small groups are inherently more risky than large groups, the next subsection presents a simple model of insurance markets.

A SIMPLE MODEL OF SMALL GROUP INSURANCE PREMIUM SETTING

To more thoroughly understand the factors operating in the MEWA market, it is important to understand the factors that influence a health insurer's determination of what premium to charge for insurance and how to market the insurance product.

We start with the premise that the insurer's goal is to maximize profits on insurance sales. This means that the premiums charged at the beginning of the year must equal or exceed the health care claims over the course of the year. Although the insurer would like to make as much profit as possible, there are limits on the premiums that can be charged, because higher premiums will result in fewer sales. Therefore, the insurer's goal is to set the premium such that, on average, it equals the amount of expected claims, plus a "fair economic profit," which is determined by competition among insurance providers. If the insurer sets a premium that is too low, it will result in losses which cannot be recovered in a later year. Because the insurance market is highly competitive, an insurer cannot raise premiums to cover a prior year's loss. To do so would be to risk being underpriced by competitors and being driven out of the market.

If the insurer could fully predict the health care use of any individual, an individual's premium could be set at that level. Unfortunately, people vary in their health care use in ways that cannot be fully anticipated by the insurer. At the end of the year, the insurer

could examine claims for groups of people to determine who used little care and who used a great deal. But some of this difference in use will relate to events that were unforeseen at the beginning of the year. For example, some people will be injured in car accidents; others may not visit the doctor even for a sore throat.

In fact, this unpredictable component of health care need provides the rationale for having insurance. Insurance enhances people's utility because it tends to equalize income over periods in which an unforeseen event occurs and in which no adverse event occurs (Arrow, 1963). Thus, people willingly reduce their current income by paying a premium for insurance that will compensate them (partly) if they suffer a financial loss.

At the end of the year, the insurer observes a distribution of health care expenditures, reflecting the use of individuals, some of whom use little health care and others a large amount. To a certain extent, the amount of health care used depends on the insurance plan the person has (Manning et al., 1987). However, in this discussion we assume that all persons have the same insurance plan. Thus, the amount of health care use reflects underlying health care needs, tastes for health care, and random events that require treatment.¹

In setting the premium, the insurer of a group of individuals does not need to predict precisely an individual person's health care use. The insurer just needs to predict the mean of expenditures for the group. The essence of insurance is that some individuals pay more premiums than they get back in payments and others get more back than they pay in. Over all the insured persons, however, these average out and the insurer covers the payouts with the premiums.²

This "insurance principle" works better for large groups than for small groups because it is easier to predict total losses accurately for a larger group.³ The smaller the group, the

¹An individual's observed health care use, U_i (given a standard insurance plan), can be decomposed into 2 parts—one systematic and one random:

$$U_i = C_i + r_i$$

where C_i denotes the systematic or expected component of health care use. This systematic component may be related to factors easily observed by the insurers (such as age, sex, presence of hypertension) as well as factors not easily observed (such as hypochondria). The term r_i represents short term fluctuations in health care use resulting from unpredictable factors (such as an auto accident). We can define the nonsystematic use as uncorrelated with the systematic use.

²Net of loading fees, the premium, p , will be set at the mean of individuals' health care costs, U_i :

$$p = \Sigma (U_i)/N = \Sigma (C_i + r_i)/N$$

³This can be readily seen by calculating the variance of the sum of expenditures:

more variable the expected payout. As in financial markets, insurers demand a risk premium to compensate them for the greater uncertainty associated with the volatility of smaller groups' claims experience. This is one reason that the loading fee is higher in smaller firms.

The insurer's objective is not to incur a loss in any particular contract. The insurer's profit is bounded by the income taken in as premiums, but the insurer's loss is unbounded because it is determined by the amount of health care used by the insured participants. Medical care utilization is highly variable, often with a small population of the claimants accounting for a large share of the costs (Duan et al., 1982). Greater variance in expected claims for smaller groups increases the probability that any given contract will lead to a loss. Insurers, like individuals, are risk averse and therefore will charge small groups higher premiums to compensate for this unlimited downside risk.

The insurer attempts to just break even on every firm because competitors will bid away firms whose premium exceeds their costs by offering a lower premium. Because the insurer cannot retain firms whose costs (including administrative costs) are lower than the premium, it has no excess funds to "cover" firms whose costs exceed premium revenues. These risks cannot be effectively pooled across firms. With large groups, insurers can estimate quite precisely the average expenditure per member. The insurer does not try to estimate which particular employees within the firm pay more in premiums than they receive in benefits because employees have implicitly agreed to pool their risks within their firm.

However, when the insurer sells insurance to many small firms, there is an incentive to identify the "winners" and the "losers," which is possible when the predictable component is large, relative to the random component.⁴ When the predictable component is large, insurers will attempt to identify individuals or firms with large expected payouts and will charge them higher premiums. By definition, they cannot identify in advance individuals or firms with large random components.

$$\text{var } p = \text{var}\left(\frac{\sum U_i}{N}\right) = \frac{(\text{var } \sum C_i + \text{var } \sum r_i)}{N^2} = \frac{\text{var } \sum r_i}{N^2} = \frac{\sigma^2}{N}$$

The equation illustrates that the larger the number of individuals whose experience is pooled in setting premiums (N), the smaller the variance in the expected use or premium.

⁴As the equation in footnote 3 illustrates, both the variability in underlying health care demand factors (C) and the random component (r) contribute to the variability in total health care costs.

When the random component is large relative to the predictable components, insurers will be more likely to pool risks and charge a single premium to all individuals. This is called community rating. Under community rating the insurer pools insurance contracts from many small firms, without expending resources to separate the systematic from the random risk.

However, when the systematic component is large relative to the random component, insurers may want to identify individuals or firms with lower than average systematic health care use and offer them a premium that is also lower than average. Both the low cost firms and the insurers find an advantage in identifying the low cost firms. Firms want to be labeled low cost, since they will be charged lower premiums. Insurers need to identify the low cost firms, because if they do not do so, another insurer may do so, and the first insurer will lose these low cost cases that are needed to offset claims from more expensive groups.

Instead of letting these low cost firms be bid away, the insurer willingly allows them to be separated from the general risk pool and offered a more attractive premium. After the firms with lowest expected costs have been removed from the risk pool, the average premium charged the remaining firms is higher. Although it would be advantageous to pool the random risk over more firms, the insurers are driven by competitive pressures to separate firms according to their systematic risk, lest they lose the low cost firms entirely from their book of business.

INSURANCE TECHNIQUES USED IN THE SMALL GROUP MARKET

Insurers use a variety of methods to identify firms that will have lower than expected costs. The first of these is age/sex rating. Because medical care use varies systematically by age and sex, insurers charge men and women and older and younger workers different premiums. In the small group insurance market, premiums are always quoted by age and sex category. However, some insurance reform proposals seek to do away with rating by sex.

A second technique used to distinguish low risk from high risk firms is medical underwriting. By asking individuals to reveal whether they have health conditions that are known to increase the use of medical care, insurers seek to identify the low risk groups so that they can be offered a lower price. The purpose of the underwriting is to determine the level of risk presented by the applicant firm and to set policy terms and rates on the basis of the information collected. By medical underwriting, the insurer seeks to learn about medical conditions that lead to above average health care costs. In this way the insurer protects against undercharging less healthy firms. Consequently, firms that employ people with existing adverse health conditions will be quoted a higher price, or perhaps not offered

insurance at all. The economic consequence of underwriting is an improvement in efficiency from the insurer's perspective, since it is able to price the product closer to its actuarially fair value. By controlling the risk directly, the insurer can reduce the loading factor that is related to risk. Further, by pricing the insurance in accord with the expected loss, the insurer is less attractive to the worst risks. Thus, the insurer can mitigate adverse selection.

Underwriting can also be used by insurers to avoid adverse selection through restricting access to insurance. Rather than charging a higher price to firms where workers have more poor health conditions, insurers sometimes refuse to provide coverage for a group that is deemed "too risky." Factors that affect an insurer's acceptance of an applicant include such items as employees' medical conditions, employees' dangerous health habits (e.g., drug abuse), as well as items that pertain to a firm's ability to pay (financial status of the firm, illegal business practices).

Yet for those employers who are denied access to insurance because of poor risks identified through the underwriting process, the practice has important social welfare consequences. For example, when the insurance industry experienced large financial losses during the late 1980s, larger numbers of small businesses found it more difficult to obtain coverage as insurers further refined their underwriting techniques as a means of preventing future losses. More careful screening of applicants resulted in an increased number of firms that were denied coverage or that were offered coverage at high cost.

A method employed by insurers to reduce their potential loss exposure is to temporarily or permanently exclude specific pre-existing medical conditions from group coverage. Among large firms who can effectively spread the risk, exclusions rarely occur. Insurers do engage in this behavior with small firms because of their more limited ability to spread risk. The method used to identify pre-existing conditions is medical underwriting. The pre-existing condition exclusions affect the availability of insurance for many employees of small firms and represent a nonprice barrier to coverage.

A third strategy used by insurers to avoid assuming bad risks is to refuse to write policies for some types of businesses altogether. Most carriers maintain a list of industries for which they will not write insurance. Included in this group are mining firms, hair salons, construction sites, and doctors' offices. The reasons they cite include: (1) a high risk of occupational illness or accidents; (2) significant credit risks for firms with high failure rates; (3) potential for high medical care utilization given seasonal work or category of employment; (4) high turnover; and (5) a high risk of AIDS. This activity, a form of "redlining" by the insurance industry, restricts access to insurance for many small employer groups.

A fourth technique is experience rating. Although we might expect the random component of health care costs to vary across individuals from year to year, it is clear that the systematic component is correlated over time. People with chronic disease or those with a taste for medical care are likely to consistently use more medical care. Therefore, this year's expenditures provide a better estimate for next year's expenditures than do medical histories, because actual expenditures include both the effect of factors that the insurer can monitor (such as whether the patient has hypertension) as well as factors that the insurer would have difficulty finding out (such as whether the individual is a hypochondriac). Experience rating reduces uncertainty for the insurer and allows a reduction in the loading fee for larger firms where experience rating is more meaningful.

Obtaining accurate information about small firms is difficult and is yet another factor that contributes to higher premiums for these groups. Our discussion of the variance of health care expenditures in small firms suggests that experience rating is a poor technique for small groups because a large share of the observed high use may relate to random factors that will not be repeated in the following year. In addition, high turnover among the employees of small firms reduces the predictive value of one year's claims experience for the next year's costs. Nonetheless, many insurers fully experience rate small firms. The result is that after experiencing high costs in one year (even as a result of random factors that are unlikely to be repeated in the next year), small firms will face steep premium increases.

Using a technique called tier rating, groups with unanticipated high costs during one year will be reclassified into a higher-rate tier in the following year. Because small groups have more variable claims experience, they are more likely than large firms to have unexpectedly high costs. Large rate increases often lead a group with poor experience to drop its coverage which, in turn, improves the risk composition of the remaining pool for the insurer.

There are clear economic incentives for insurers to lower their overall risk exposure by making the product too expensive for less desirable groups. Because small groups have more variable claims experience, they are more likely than large firms to have unexpectedly high costs. Large rate increases at renewal time encourage firms to move to another insurer, and high premium quotes at the initial time of purchase keep bad risks out of the pool. Although access to insurance may not actually be denied, small groups are likely to find the product unaffordable. This is tantamount to restricting access to insurance through strategic pricing behavior. This may be the preferred strategy from a public relations standpoint, in lieu of cancelling a policy at renewal time.

The difficulty of obtaining insurance after a single year of poor claims experience has led many small firms to turn to pooled plans such as MEWAs to provide a larger risk pool that will insulate them from the effects of a single illness episode. However, as our discussion of medical underwriting suggests, combining employees across many firms is not equivalent to insuring one large firm. Workers within the large firm have committed to pool risks. No such agreement exists across the small firms. Small firms who find that their claims experience has been more favorable than average will pull out of the risk pool to find less expensive insurance elsewhere, on the basis of their own low claims level. When the "cheaper" firms have withdrawn, the insurer will be left only with the more expensive firms. The cycle of withdrawal of the better risks and consequent increase in premiums that causes yet additional withdrawals may continue until the pooling arrangement dissolves.

THE ROLE OF MEWAs IN THE SMALL GROUP MARKET

Despite the difficulties inherent in pooling arrangements, the lure of reducing variability in claims experience and lowering administrative costs has led policymakers to look to pooling arrangements such as MEWAs as a way to provide affordable health coverage to small firms. MEWAs have attracted business by providing lower premiums than regular insurance companies. However, as we have seen, they are likely to attract only the higher cost firms that cannot find health coverage at reasonable rates elsewhere. Thus, unless MEWAs can effect substantial cost savings, they are inherently unstable.

It is not clear that pooling coverage under a MEWA will avoid the high administrative costs that plague the small group market for health insurance. Administrative costs may be nearly as high for MEWAs as for traditional insurance firms. Small groups must still be sold policies on a firm-by-firm basis and these small businesses continue to require large amounts of administrative support. On the other hand, because medical underwriting is used less extensively by MEWAs than by other insurers, some costs may be reduced.

Risk pooling by MEWAs can potentially spread risk over many small firms and may increase the stability of the risk pool. However, MEWAs face the same incentives as conventional insurers to limit their risk exposure. Because they are less likely to rely on medical underwriting, MEWAs may be offering lower premiums to businesses that have difficulty finding conventional insurance because they present a poor risk profile. However, this lure will result in a high cost profile for the MEWAs.

MEWAs typically do offer lower premiums than conventional insurance companies. At times the premiums are set below actual costs as in a Ponzi scheme arrangement (described in the next section). State regulation does increase cost. By ignoring state regulation,

MEWAs have avoided premium taxes, state mandated coverage requirements, and reserve requirements, and thus have operated at lower cost and with lower premiums.

Although avoiding state regulation may lower costs, it also increases the risk of financial insolvency. By avoiding the opportunity cost of maintaining larger reserves against claims and by not contributing to state insurance guarantee funds, the MEWA is transferring risk to its subscribers. Large reserve funds mean that insurers are less likely to face claims that exceed their liquid assets in any given time period. However, insurers are required by state regulators to maintain their reserves in safe investments. Individual firms may be able to earn a higher rate of return on these reserves than the relatively low rate yielded by the "safe" investments required by state regulation. Because the individual firm has other assets (buildings, capital equipment) to borrow against to cover health care costs, it may be possible for firms to safely have a lower reserve level against medical claims than insurers without other assets.

Premium taxes also add to the cost of insurance but guarantee that individuals' insurance claims will be paid in the case a particular insurer goes bankrupt. As in other financial markets, greater protection against risk (e.g., purchasing an insurance product that is backed by a state guarantee fund) is associated with higher cost (premium). However, the transfer of risk directly back to the subscriber is not well understood by the purchasers of MEWA policies. Purchasers believe they are purchasing a product identical to insurance at a lower price. In fact, they are purchasing a product that entails considerably greater risk of nonpayment than conventional insurance. The difference in price between the MEWA product and insurance may be more than made up for in the greater risk because MEWAs do not participate in a state's guarantee fund and because of the lower level of reserving against future claims. These factors lower costs, but they increase risk.

In a sense, MEWAs rely on the consumer's lack of information about the greater risk attached to their product. The market may have appropriately priced the difference in risk, but consumers mistakenly believe that the coverage they get from a MEWA is identical to insurance. An analogous situation prevailed in the savings and loan industry, where state insured banks quoted higher interest rates than federally insured banks. However, state bank failures were not insured by the Federal Savings and Loan Insurance Corporation (FSLIC) and when state chartered banks failed, many depositors lost money. However depositors in federally chartered banks had their losses covered by the FSLIC.

Individual firms that self-insure also do not contribute to state guarantee funds because of ERISA preemption. Yet, in contrast to MEWAs, there have been few failures of self-funded plans that are covered under ERISA. One reason for this is that self-funded

single employers have physical capital that can substitute for a part of formal reserves. An on-going business is unlikely to declare bankruptcy as a result of high medical costs. Unlike self-funded plans, MEWAs do not have other assets that can be drawn upon as substitutes for formal reserves. For a MEWA, the medical costs are their business and there are no other assets to draw on. The theory of risk based capital requirements suggests that reserve requirements should be greater where there is no other source of capital to cover potential losses. The next section describes the types of MEWAs that have evolved and the difficulties they face as a result of the inherent instability of pooling across firms.

3. TYPES OF MULTIPLE EMPLOYER ARRANGEMENTS

Health coverage that involves more than one employer can take in a variety of organizational structures. Categorizing the various types of MEWAs is difficult for a number of reasons. Foremost among these is the fact that different agents may use different terms to refer to the same entity. An additional problem that precludes the use of traditional labels to categorize plans concerns the fact that MEWAs may take various forms; they may be fully insured or self-insured, "legitimate" associations or sham ones.

Although some evidence exists to show the better viability of one type of structure over another (fully insured versus self-insured), the distinctions themselves do not always hold up. In fact, the viability of the type of structure may depend more on the regulatory environment in which the entity functions, which may or may not contain specific provisions to ensure the plans' solvency. Indeed, the definitional difficulty concerning MEWAs may have contributed to confusion as to who bears the responsibility for regulatory oversight of such plans. With the caution that our description deals in generalities, for which there always seem to be exceptions, we attempt to address some of the definitional issues concerning MEWAs. From this review, insight may be gained about how to structure solutions to the problem of MEWA failures.

REGULATORY VERSUS INDUSTRY DEFINITIONS

State and federal regulators understand that the definition of "multiple employer welfare arrangement" (MEWA), added to ERISA by the Erlenborn Amendment in 1982, encompassed all types of insurance-like arrangements that involve more than one employer, regardless of their corporate structure, insurance status, or status as an "employee welfare benefit arrangement" subject to ERISA. The Erlenborn Amendment specifically excludes from the definition arrangements that the Secretary of Labor finds to be collectively bargained plans, and those organized by rural electrical cooperatives and rural telephone cooperatives. Thus, except for any underlying insurance company products, these entities remain exempt from state regulation despite the Erlenborn Amendment's broad language. ERISA also explicitly exempts from its coverage those employee benefit plans established or maintained by state and local governments or for religious organizations for their employees. State regulation of these entities is not preempted by ERISA.

Although some insurers and agents with whom we spoke understood the term "MEWA," most continued to use the phrase "multiple employer trust" (MET) to describe all

of these entities. Insurance industry members, however, use the phrase "MET" to describe a specific device that has existed for many years: the administrative vehicle with which insurers group together small business into "trusts" for rating and marketing purposes. These trust products are sold as fully insured plans. Some insurers use separate METs for each industry category (SIC codes) or group policyholders based on the period in which they enrolled. Each method of grouping the small employer business was viewed as a way to keep "similar experience" groups together for rating purposes. Individual employers generally are unaware that they are enrolled in a MET.

It is important to understand insured METs as a basis of comparison for "uninsured" MEWA arrangements. Also, the fact of their existence and generally higher cost than uninsured plans no doubt contributed to the development of other types of multiple employer arrangements. To avoid confusion in the discussion that follows, we refer to these types of plans as "insurance company METs" distinct from all other types of MEWAs. When both insurance company METs and MEWAs are included in our discussion, we use the phrase "multiple employer arrangements."

Although MEWA plans that are organized as insurance company METs can raise problems for small employers by, for example, unilaterally cancelling all coverage for a particular type of industry, by and large they tend to be fairly well run and solvent. This is because they tend to follow the business practices used by traditional insurance companies such as underwriting all business, setting aside reserves, fully insuring the risk, and establishing actuarially sound rates given the risk that is accepted. As a result, insurance company MET plans tend to be more expensive options for small employers than plans that do not follow standard insurance industry principles.

USE OF THE TRUST CONSTRUCTION FOR MULTIPLE EMPLOYER ARRANGEMENTS

Before describing the different forms MEWAs take, it is important to understand the prevalence and purposes of the use of trusts by nearly all forms of multiple employer arrangements. Although some of the reasons for forming as trusts are common among all types of plans (i.e., avoiding state "franchise" regulation), others are specific to the type of arrangement (i.e., administrative ease for insurance companies; compliance with ERISA, or tax advantages for others).

Historically, insurers organized small group multiple employer plans around trusts to avoid certain types of regulation imposed on "franchise" (small group) and individual policies. In a trust arrangement, the insurance policy is issued to the trustee (in the case of an insurance company MET, typically a bank or other financial institution). "Certificates"

rather than "policies" are then issued to individual participants. Insurers can then avoid regulation protecting individual "policyholders" such as rate review and prohibitions on unilateral policy changes. Insurers may use the bank/trustee's name to promote these METS, hoping to encourage greater confidence in the product. Also, incorporation as a trust may allow an insurer to choose a state with less-stringent regulation in which to incorporate, because the law of the state where the trust is domiciled typically governs it. We did observe some tendency for this activity to decline as states became more aggressive in regulating this behavior. Connecticut, for example, does not allow an insurer to market a trust product unless the trust is located in Connecticut.

MEWAs also use the trust device to qualify for particular tax treatment. "Bona fide associations" (i.e., those existing for purposes other than the provision of insurance, with independent oversight by members) can qualify under IRS Code Sec. 501(c)(9) as a Voluntary Employee Benefits Arrangement. This allows the association to directly control collection and investment of premiums, pre-fund on a limited basis, and enjoy tax-free buildup of interest returns. Similarly, some uninsured MEWAs attempt to use the trust device as part of their false claim that they are "employee welfare benefit plans" and exempt from state regulation under ERISA.

TYPES OF MULTIPLE EMPLOYER INSURANCE ARRANGEMENTS

Insurance-Company-Sponsored METS

MEWAs that are sponsored by insurance companies tend to be organized as trusts, and as such are referred to by insurers as METs. Information in this section is based on interviews with insurers, regulators, and policymakers. Insurers are very careful to distinguish their MET products from MEWAs, which they consider to be very different and acting outside any type of insurance regulation. The segregation is undoubtedly due to the large number of MEWAs that have become insolvent and potentially threaten to harm the reputation of all multiple employer plans.

Insurance company METs do differ from the other types of MEWAs that will be discussed in the following pages. The primary distinction is that these MET plans are marketed as fully insured products by insurers who are authorized to sell insurance in the states in which they operate. As a consequence, these plans are required to comply with state insurance regulations concerning the financial solvency of the plan, such as having to post a bond to do business, setting aside reserves, and paying premium taxes to state guarantee funds. The insurers we interviewed described the operation of the MET plans as being run according to standard insurance practices.

Another factor that seems to promote the financial soundness of insurance company METs is direct and experienced trustee oversight of the insurance plan to ensure that funds are appropriately managed. Because the plan is usually operated in this case by individuals who are knowledgeable about the workings of insurance, they engage in practices to ensure the long-term viability of the firm. For example, all insurance company METs that we investigated perform medical underwriting for their small group product and do not guarantee coverage to any group. In fact, many stated that they are completely unwilling to accept certain industry groups (e.g., mining, construction, medical groups, hair salons, florists, and lawyers) because these groups pose an "unacceptable" risk. In fact, METs compete aggressively for the best risks in the small group market and offer those firms the lowest premium rates available. This leaves many small firms without the MET insurance option, either because they are denied coverage because they are considered an unacceptable risk or because of high premium costs for being high risk. By segmenting the market, insurance company MET plans select the better risks and drive the poorer risks toward other MEWA plans that do not engage in underwriting and that offer guaranteed issue of insurance. Because of this practice, MEWA plans may have higher risk pools of covered individuals; however, no data exist to confirm this.

By underwriting the groups that the MET agrees to accept, insurers are able to base premiums on actuarial principles designed to protect their profits and solvency. Because insurance-company-sponsored METs operate virtually identically to individual and large group insured health plans, they tend to be more expensive than the other types of MEWA plans discussed below. They also tend to be more financially stable.

Association Plans. There is no such thing as a generic association plan. Long-established business associations sponsor health plans that may be either fully-insured or self-insured. Some insurers or TPAs may claim to represent an "association," though they simply establish a plan and then market it somewhat indiscriminately to individual employers who may or may not fall into a particular industry or professional grouping (e.g., florists or lawyers). The different types of MEWAs that legitimately and illegitimately use the "association plan" title are described below.

Fully-Insured, "Bona Fide Association" Plans. Many long-standing groups, formed for purposes other than providing insurance, sponsor health insurance plans. These plans often are underwritten by insurance companies, which use standard insurance practices to decide whether to cover particular individuals and may or may not pool all association members together for rating purposes. Some insurers reported that association rates may be slightly lower than their standard MET plans or individual policy prices;

however, other carriers stated the opposite. For these insurers, their association business has matured and their rates have become expensive compared to rates for other insured groups in their pools. "Bona fide" associations may have greater incentives to monitor their plans to assure the best value and service for members, as well as to assure that the organization's name is not affiliated with financially questionable operations.

Insurers stated that they saw administrative efficiencies in offering association-sponsored plans, particularly the ease of marketing the product as part of the accoutrements to membership. It must be noted, however, that some insurers expressed serious doubts about the continued viability of association-sponsored plans. Membership in association plans tends not to be guaranteed or stable, and it often peaks after a certain amount of time. Without the influx of new members, the groups' risk profile tends to deteriorate, which forces premiums to increase. Furthermore, because 100 percent participation in the health plan by association members is not required, individuals are free to move in and out of the plan at their choosing. The voluntary nature of association business and the price sensitivity of small employers has a tendency to make individual employer members switch plans frequently in search of better pricing when premiums rise. The turnover of firm members in the association plan typically results in a highly unpredictable group. Also, for those association MEWA plans that pay claims out of cash flow, the inability to continually attract new members can force the plan to become insolvent once the claims tail (i.e., lag in the submission of claims for payment) catches up with the collection of premiums.

Self-Insured, "Bona Fide Association" Plans. The success of self-insured association plans appears to depend to a great degree on the regulatory environment in which they function. Among the individuals we interviewed, some described legitimate associations which sponsored self-insured plans without adequate management, including the failure to reserve, to rate realistically, or to seek stop-loss coverage. For example, a plan sponsored by an association of schools in Texas decided to self-insure and hired consultants to assist the association with establishing a self-funded plan. The consultants apparently failed to provide adequate advice, and suggested that the association need not contract for stop loss. It took only two years for the claims lag to catch up with the association, and it is now mired in litigation resulting from the insolvency. Similar stories also exist in Florida, which has a statute specifically requiring the licensing of local self-insured, association-sponsored plans. Until recently, Florida law did not set financial standards or reserve minimums, and a number of plans licensed under the lax law failed. It may also be that the unstable and unpredictable nature of this business, as described above by insurer sponsors, cannot support the self-insured status.

Michigan, as a regulatory example, presents an entirely different story. About 20 association-sponsored plans have succeeded in this state because they are held to financial standards similar to those of standard insurance companies. Also, the TPAs that manage these plans appear to set appropriate rates and engage in medical underwriting, yet still manage to offer a competitively priced alternative for small business members of associations. In this case, the self-funded association plans have proven to be viable health coverage alternatives.

Insurer Created "Pseudo Associations." In some cases, entrepreneurs, in conjunction with small insurers, may create organizations that claim to represent an interest group, allegedly for purposes other than seeking insurance. TPAs will create the group, market it, and then seek health insurance coverage from a small insurer in need of quick cash flow. Often these small insurers are not financially sound themselves. The "pseudo" association plans then seek the "group" label to avoid more stringent state regulation of individual plans and to enjoy "reciprocity" offered by some states to other states' "group" designation.

Regulators believed that these types of plans were inherently less stable than standard groups for the same reasons noted for bona fide association plans. In addition, pseudo association leadership does not provide the protective oversight as in the case of bona fide associations to assure that members are not exploited or that the sponsor is not mismanaging the plan funds. This is particularly true concerning overseeing the quality of the insurer that may be backing the plan. Several states have recently instituted policies or passed legislation to screen carefully any plan claiming to be an "association" in an effort to assure that the organization is bona fide.

Entrepreneurial Self-Insured Plans and "Ponzi Schemes"

From our interviews, we learned that some TPA-initiated multiple employer welfare plans did not seek insurance coverage at all or continued to sell health plans after their insurers dropped coverage or became insolvent. As a result, these types of MEWAs function in a self-insured fashion and bear full responsibility for the risks, facts often unknown to the plan members. Such arrangements may attempt to legitimize themselves with an association label or falsely advertise that they are insured when, in fact, they maintain only an Administrative Services Only (ASO) contract with an insurer.

Self-funded MEWAs have other characteristics in common. They tend to guarantee coverage to any firm that wants to purchase coverage. They also typically set very low premiums, sometimes up to 40 percent below comparable insured small group plans. Many

of these MEWAs fail to engage in formal reserving and claim to rely on stop-loss coverage to pay claims that exceed premiums. However, although they may pitch stop-loss coverage as if it were full insurance coverage, the stop-loss coverage usually becomes available only after the amount paid on an individual claim or on all claims in the aggregate exceeds a certain amount ("the attachment point"). Insolvent MEWAs generally are unable to pay the claims that would activate the stop-loss insurance.

Increasing numbers of self-funded MEWAs market their plans directly to small employers, in lieu of marketing through brokers and agents. Agents who may be better informed about the questionable financial status of these plans are not used. For example, one agent reported that one plan gave itself an industry name such as the Flowergrowers Health Plan, purchased a mailing list for all companies within that industry, and then approached the companies directly, claiming to have a tailor-made product. Because agents and brokers are increasingly left out of the sales process, regulations that attempt to stop the sale of MEWA products by agents and brokers are likely to be ineffective.

Because these MEWA arrangements do not set aside reserves, they must pay claims out of incoming premiums on a cash flow basis. This strategy works only if enrollment in the plan continually increases, which may happen initially but cannot be sustained. Because of the delay in receiving and processing health care claims, such MEWAs are able to flourish for a period of time. One regulator said that it may take 12 to 18 months for the claims tail to catch up, although some MEWAs have been able to survive for longer periods before experiencing difficulties. Eventually, the MEWA starts to slow its claims payment, fails to pay large claims altogether, and then either declares bankruptcy or, sometimes under pressure from regulators, quietly slips out of the state.

Although regulators stated that some of these MEWAs were simply naively mismanaged, the worst offenders clearly were conceived to exploit the public and reap short-term personal rewards. These, like the well-publicized Rubell-Helms enterprise in California, collect extremely high administrative fees and "consulting fees," while charging expenses such as yachts, new wardrobes, and personal trainers to the company. In the case of Rubell-Helms, all claims were paid from premium-generated cash flow until the money ran out. It is virtually impossible to know what percentage of all self-insured arrangements are "ponzi schemes" and how many are good faith efforts run by inexperienced individuals.

ASSOCIATE UNION MEMBERSHIPS

Background

Alternative methods for structuring MEWA-type plans have recently emerged. One such method is "associate" union memberships for non-union employees and employers. Union-sponsored health plans, which open enrollment to non-union individuals, may be operating like MEWAs by providing health coverage to multiple employers often in a self-insured fashion. These types of health plans claim preemption from state insurance regulation because they operate as "collectively bargained" plans under ERISA and the Taft-Hartley Act, and not as MEWAs. Collectively bargained plans are excluded from the definition and thus are preempted from state regulation under ERISA. Furthermore, the federal regulation (under ERISA) that applies to these self-funded plans relates to plan structure and not to funding standards designed to protect the solvency of the plan. Because state and federal governments exercise only minimal oversight over these health plans, insurance regulators fear the potential for the same abuses observed with MEWAs.

Many state insurance regulators are concerned that these plans function as insurers in an unregulated manner and closely resemble MEWAs in their structure and operation. Virtually all of these entities are self-insured or partially self-insured trusts, and it is unclear whether they set aside sufficient reserves to prevent insolvencies that can result from large claims. Several regulators also questioned whether a "collectively bargained plan" preemption was warranted under circumstances where the union opened its doors to market insurance products to non-union employee groups.

Union plans that engage in this activity typically function in the following manner. They solicit associate members among employees of small companies, who are given the opportunity to join the union for the expressed purposes of gaining access to the union's health benefits program and other assorted union-sponsored services (e.g., dental insurance, credit unions, legal aid, and mail-order pharmaceuticals). Associate members pay dues to the unions and, in return, are given a few of the privileges of the union members who are covered by collective bargaining provisions of the union's contract. By joining the union as an "associate" they are not part of the union's organized bargaining unit, nor are they usually employed by companies with which the union has a labor contract.

The preemption claim is at the heart of the debate about whether union plans that allow associate memberships should be allowed the preemption from state regulation afforded to "collectively bargained" plans. What is unclear is whether the health plans provided by unions that offer associate union memberships are truly collectively bargained.

Some health plans may be but not for associate members. Other health plans may not be truly collectively bargained at all.

Reasons Association Memberships Exist

Associate union memberships are especially attractive for certain individuals and employers, particularly small employers, who experience difficulty in gaining access to health coverage because of exclusions for preexisting conditions or because they fall into a high-risk industry category (e.g., hair salons, construction, florists, lawyers). A number of unions allow associate members access to their health plans on a "guaranteed issue" basis, which allows all individuals to enroll regardless of risk status. Often these plans guarantee issue to firms with as few as one to five individuals with no prior proof of insurability and no medical underwriting. Additionally, associate members are provided the opportunity to purchase health benefits and services at or below the price they would otherwise face in the market. Such plans, however, provide ample opportunities for adverse selection of risks into the union pool, which is a common problem observed with MEWA plans. Regulators are concerned that when adverse selection is combined with unsound actuarial practices, the risk of insolvency rises dramatically.

From the union's perspective, associate union members serve several functions. The first and probably the most important function is that they provide a critical source of revenue to the union because they pay dues and fees for services they select. An example is the Mail Handlers Union, which has roughly 50,000 full-time union members, yet has nearly 500,000 associate members who subscribe to its health plan and pay dues. The International Ladies' Garment Workers' Union also reports using associate memberships to stave off dwindling membership and to attract new dues-paying members. Annual membership fees for associate members average between \$30 and \$50. Indeed, some unions rely on income from their health plan subscribers to help keep the union operating. Associate memberships have become exceedingly important to unions, given recent declines nationally in union membership from 23 percent of the total workforce in 1980 to 16.4 percent in 1990.

Second, unions may view providing health and other benefits to small employers who experience difficulty in obtaining such benefits as a good method to sell the advantages of unionization. The AFL-CIO currently uses associate memberships as a means of gaining a foothold in selected industries with high turnover that it has found difficult to organize, such as the service industry. Although the AFL-CIO has more than 14 million members, it actively seeks to expand membership through a program entitled Union Privilege—which contains incentives for members to stay in the union and includes associate memberships.

The AFL-CIO hopes that associate memberships can eventually be used to convert non-union worksites into union shops.

Third, associate memberships are a way to maintain a larger public profile. Unions use the opportunity to provide health and other benefits as a marketing tool to attract members and to remain relevant for present members. This approach may be more suitable to today's workforce, instead of the more traditional labor concerns of wages and working conditions which have become more difficult issues to address with increased international competition and the deregulation of some heavily unionized industries. By increasing their membership through associate members, unions hope to become a larger economic and political force. As a result, the union is able to marshal greater purchasing power to expand the range and improve the quality of service offerings.

Fourth, employers may view associate union memberships as a way to fend off true unionization of their workforce while gaining access to health insurance at more attractive rates. Employers may be able to provide desired benefits to employees by buying into unions as associate members, without directly entering into a collective bargaining agreement. Employees are given benefits and the employer avoids becoming a union shop.

Regulation

Union health plans that have associate members may not be MEWAs as defined under Section 3(40) of ERISA. For example, in Advisory Opinion 91-06A, the Department of Labor concluded that the Diversified Industrial Group (DIG) plan, a self-insured trust that provides health care benefits to members of the International Union of Petroleum and Industrial Workers (IUPIW), was not a MEWA even though it covered associate union members. The membership of IUPIW consists of individuals working in bargaining units and associate members who are not part of an organized bargaining unit. At the time the opinion was issued, the number of associate members who could vote in union elections and hold union office equaled or exceeded the number of members covered under the collective bargaining provisions of the IUPIW contract.

The Department of Labor determined that DIG was established and maintained pursuant to various collective bargaining agreements between the union and various employers. The department stated that if the agreements between the union and the employers establishing DIG were found to be collective bargaining agreements, DIG would not be considered a MEWA under ERISA but would be an employee welfare benefit plan as defined under Section 3(1) of ERISA, and therefore exempt from state insurance regulation.

A so-called union-sponsored health plan that has received considerable attention is the Consolidated Welfare Union Fund, which initially was fully insured by Empire Blue Cross and Blue Shield of New York. Problems developed with this arrangement when the organizers used the Empire BCBS affiliation in marketing the plan outside New York, when in fact, Empire was not licensed to provide insurance to individuals who reside outside the state of New York (i.e., Empire was not authorized to sell insurance in any state but New York). The Empire BCBS affiliation was used as a strategy to enhance the credibility of the plan to prospective buyers. Once Empire became aware of the marketing of the Consolidated plan outside of New York, they terminated their contract with Consolidated and the plan was no longer fully insured. Consolidated did continue to offer the health plan throughout the United States, but on a self-insured basis. Regulators expressed their concern that Consolidated was operating as a self-insured, multiple employer plan, outside the purview of any insurance regulation.

It is not known how many unions offer associate memberships, since little research has been conducted to study this issue. As of 1987, several major unions, including the Steelworkers, Machinists, AFL-CIO, and Service Employees, had adopted or were considering adopting associate memberships. The total number of associate members was estimated at 300,000 as of April 1989 (Kerr, 1991).

EMPLOYEE LEASING FIRMS

Background

Another device used by health plan organizers to avoid state regulation is employee leasing firms. These firms nominally hire the employees of many firms and then lease them back to the individual employers on a contract basis. Many leasing firms offer significant cost benefits to employers by pooling large numbers of employees from different businesses to provide a discrete set of services. The firms that market this service agree to handle certain administrative functions and, in some cases, to provide benefits to the leased employees. Many of their clients are small firms, which may not have the time or staff to do the work themselves or may not have the financial resources to purchase benefits. Other leasing firms, however, may engage in practices that are intended only to avoid state insurance regulation by setting up self-funded health plans for multiple employers.

In 1983, fewer than 4,000 employees were leased. This number increased to 50,000 by 1984. The current number of leased employees nationwide is estimated to be between 1.5 and 2 million and is projected to grow to 10 million by the year 2000. The National Staff Leasing Association (NSLA) estimates that currently there may be as many as 1,500 leasing

firms. Of the total, only 183 belong to the national association. This fact is important, given that the NSLA is seeking to move the industry toward self-regulation, because of a number of highly publicized health plan insolvencies which threaten the existence of well-managed leasing firms. The NSLA recently established a voluntary set of standards for their members, who, they acknowledge, are essentially unregulated entities. Although these efforts may set good practice standards for the members of NSLA, 90 percent of all leasing firms are outside the purview of NSLA and its standards. Thus, the majority of all leasing firms adhere to no industry-imposed guidelines or state regulations intended to ensure the solvency of their health plans.

Until 1988 most leasing firms offering health coverage were fully insured, according to one industry spokesman. Then, in response to large losses faced by many insurers, premiums increased by 30-40 percent, making the insurance less affordable and causing many firms to switch to self-funding. Many carriers also decided to stop underwriting leasing firm business. Insurers argued that they had no "underwriting control" because leasing firms were completely free to determine the risks that entered their pool. This provided a fertile opportunity for adverse selection of risks, particularly since many of the client firms that entered into leasing arrangements were previously without health insurance, possibly because of their poor risk status.

Many leasing firms do not purchase insurance but rather self-insure. At present, between 60 and 70 percent of all leasing firms self-insure their health benefit packages. Because they are the nominal employer, they seek preemption from state regulation as a single employer plan, and therefore not a MEWA citing ERISA. The leasing firm's status as the "employer" may in some cases be a fiction, created to provide insurance outside the purview of state regulation. Often these self-insured plans lack adequate reserves or do not charge sufficient premiums to assure their solvency in the long run. Several large and well-publicized insolvencies have created new concerns about the legitimacy of health plans offered to many different employers through leasing firms and the competency of the managers who administer the plans. Leasing firm plans that have become insolvent include CAP Staffing, Synesys, American Workforce, ATS, and Criterion.

Leasing firms tend to be heavily concentrated in Florida, Texas, Oklahoma, South Carolina, New York, New Jersey, and California. This may be due to the large concentration of small businesses in these states, many of whom offer no health benefits to their employees. Out of 580,000 employers in California with fewer than 100 employees, 35 percent offer no health benefits. This represents a substantial market to be tapped. Benefits, such as health insurance, are viewed by small employers as an important means for attracting high caliber

employees and reducing turnover—particularly if they can “purchase” those benefits at an unusually low cost through a leasing firm’s plan. Some leasing firm plans mimic MEWAs in this instance by offering very low premium rates, generally because no attempt is made to establish rates on an actuarial basis and therefore the plan is not adequately funded for the expected loss profile of the enrollees.

Reasons Employee Leasing Firms Exist

Leasing firms exist and are attractive to some employers for several reasons. Leasing firms provide a valued set of services to employers, such as screening job applicants, preparing payroll, paying payroll taxes, and filing required government records. Each of these tasks is time-consuming and burdensome, especially for small employers who do not maintain full-time personnel/benefits staff to manage such activities. Leasing firms claim that they can perform the administrative tasks more efficiently because they are fully dedicated to do so, and as a result are able to provide the services at a lower cost than the client employer is typically able to do. Also, for firms that have worksites in many locations throughout the country, a local leasing firm may be better positioned to negotiate more favorable health benefits in different markets.

In marketing themselves, leasing firms cite the importance of a larger pool of employees to form a “buying group” to secure a cheaper package of benefits, which they can then provide to the employer’s leased employees. Many leasing firms employ several thousand employees, and as a result, they can negotiate better pricing on health insurance and other benefits than a small firm with 25 or fewer employees. Leasing firms see the provision of a rich set of benefits as an attractive marketing vehicle to small employers in particular, since many of the leased employees were previously without benefits before the leasing arrangement.

In our interviews, we discovered that among some leasing firms in the past, there may have been no uniformity of benefits provided to the leased employees. Representatives from the leasing industry cited examples where an employer decided not to “purchase” health insurance for some or all of the employees it leased. They also expressed their belief that some employers had used leasing firms to avoid having to provide benefits to certain classes of employees. Low wage workers or those employees who frequently change jobs were among those typically excluded from the benefit. In this situation, the leasing firm appeared to service the different needs of multiple employers and did not behave as a single employer. This issue raised questions about the legitimacy of claims made by some leasing firms who

stated that their health plans were exempt from state insurance regulation because they were "single employers" offering a self-funded plan.

A major impetus for their creation is to obtain low cost workers' compensation insurance. Leasing firms reportedly have been able to secure lower rates for workers' compensation by : (1) claiming to be a new firm without any prior claims experience against which to rate, or (2) periodically changing the name of the leasing firm, leaving no claims trail for an insurer to check. By claiming to have "no prior experience," a leasing firm's premium will be set at the average for all such businesses. This may provide substantially lower workers' compensation premiums to firms where the employees have actually worked and accrued an unfavorable claims record. Furthermore, because premiums are based on occupational categories, some leasing firms will knowingly misclassify employees into lower risk categories (e.g., truck drivers classified as clericals) to obtain lower rates.

Regulation

Many leasing firms operate using sound business practices; however, regulators have identified major problems with some labor leasing firms. These include: (1) defrauding the workers' compensation system; (2) defrauding state assigned risk pools; and (3) acting as unauthorized insurance operations, which poses considerable risk for insolvency. For these reasons as well as leasing firms' similarities to MEWAs, regulators in several southern states expressed concern about them, given that the market is growing and the states' authority to regulate these entities is unclear. One estimate places the annual rate of growth of employee leasing firms at 30 percent.

The insolvency of CAP Staffing provides insight into the problems associated with MEWA-like health plans offered by leasing firms. CAP Staffing was federally indicted in 1989 for selling phony employee health insurance and other benefits to more than 120 employers in eight states. Over a five-year period, the plan reportedly bilked customers out of millions of dollars in premium payments and left more than 13,000 workers and families without health care coverage. CAP Staffing claimed that its health plan was insured by Travelers, when in fact, it was self-insured. Travelers was contracted with to provide only administrative services support, such as claims payment, without any assumption of the risk.

Investigators determined that CAP Staffing experienced difficulties in meeting its financial obligations because it charged premiums well below what was required to cover claims expenses based on actuarial calculations. In this case we see many similarities to MEWA plans, since CAP Staffing was operating in a self-insured manner, not setting aside reserves, pricing below what was actuarially sound, falsely advertising to be fully insured,

accepting all risks (i.e., guaranteed issue), functioning as an insurer, selling to many separate and different employers, and operating outside the purview of state insurance regulation by claiming to be a single employer. It is these similarities that have state regulators worried about the increased prospects for plan failure.

Currently, if leasing company plans are considered to be single employer plans they are not required to set aside reserves to pay claims from a health trust. Regulators believe that reserves are necessary to ensure the solvency of these plans and to adequately protect participants from losses that may arise from unpaid medical claims.

Among the state insurance departments we interviewed, many stated that employee leasing firms present a regulatory grey area, since it is not clear what these entities really are. The primary reason for the lack of clarity is that the employment relationship is not clear in many instances. For example, the leasing firm is likely to claim that it is the sole employer for the purposes of providing an employee welfare plan; in doing so, the leasing firm can then claim to be exempt from state health insurance regulations, such as reserve requirements and benefit mandate laws. However, some individuals who were interviewed stated that a leasing firm may claim a joint-employer relationship for other purposes, as in the case of wrongful termination litigation and discrimination complaints. In this instance, the leasing firm would not be held entirely responsible for the actions taken against employees. Rather, the employer would share in the liability. Depending on the specific need, it appears that some leasing firms choose to establish either a single- or joint-employer relationship.

Leasing firms do, in fact, consist of a collection of employees from many different, unrelated employers. Because the leasing firm is acting as "an insurer" to many employers, state regulators claim that leasing firms are unauthorized insurance operations. Therefore, they assert that health plans offered by leasing companies should adhere to the same regulations required of other insurers who provide plans to the employees of many different firms. Furthermore, like MEWAs, a large percentage of the plans offered by leasing firms self-insure, which enables the plan to claim preemption from state insurance regulation. Regulators expressed their concern about the self-insurance status of these firms, because they believe many of the leasing plans operate on a cash flow basis, like many of the MEWAs that have failed.

The issue of the employment relationship is central to the question of whether or not a leasing firm's plan is a MEWA. In this regard, the U.S. Department of Labor (DOL Opinion No. 91-17, April 5, 1991) has taken the position that whether an employment relationship exists is to be determined by applying common law principles, taking into account the

remedial purposes of ERISA. In that opinion, the Department of Labor concluded that a particular leasing firm's health benefit program was a MEWA because the covered individuals were employed by the client-employers, rather than by the leasing firm.

ESTIMATING THE NUMBER OF MEWAs

No reliable estimate of the number of MEWAs is available. One published estimate puts the number as "at least 3000" (Konrad et al., 1991). However, this number is impossible to verify. It is very difficult to estimate the number of MEWAs because most operate as unlicensed insurers. Their incentive is not to be found or counted by federal or state regulatory authorities. There is a belief, however, that the MEWAs that have come to public attention as the result of criminal behavior represent only the tip of the iceberg.

In our interviews, we asked state insurance commissioners to estimate the total number of MEWAs operating in their state and not just the number that were currently being investigated. Some states could not provide an estimate. In other states we felt that the estimate might be low because they did not have a good mechanism for obtaining information about MEWAs until an insolvency occurred. In Virginia, we believed the number of MEWAs headquartered there was high relative to the population because many associations have their national headquarters in the Washington, D.C.-Virginia area.

Similarly the purchasers of health insurance policies cannot be relied on to report that they have their coverage through a MEWA. As our discussion above points out, buyers of MEWA plans are often unaware of the distinction between a MEWA and conventional insurance. Calculations from a survey conducted by the Health Insurance Association of America show that 10 percent of the small firms they surveyed (under 20 employees) reported that they were insured through a "Multiple Employer Trust." It is difficult to translate this number into an estimate of MEWAs because conventional insurance companies often place their small group business into METS, as described above.

In addition, other arrangements, such as associate union memberships and employee leasing firms that offer health insurance, behave in ways similar to MEWAs. Thus a count of MEWAs alone would provide only a partial assessment of the scope of the problem.

4. STATE REGULATION OF MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

Much has been said and written about the problems surrounding the regulation of MEWAs, including allusions to the "regulatory black hole" some claim exists. This characterization is, of course, a vast oversimplification of a complex problem arising from a system that recognizes the appropriateness of both federal and state authority in the area of employee welfare plans and their "insurance" elements. This section on state regulation of MEWAs contains four parts. The first part summarizes relevant federal legislation of MEWAs under ERISA and briefly describes the issues underlying this joint regulation. The second part uses information gathered in our interviews with state Departments of Insurance to characterize the various regulatory regimes that exist across the states. In the third part, we analyze how these different regulatory schemes appear to affect the way MEWAs behave and move between jurisdictions. The final part contains conclusions.

RELEVANT FEDERAL LEGISLATION

To fully understand state reaction to and regulation of MEWAs, one must understand the context of federal regulation and the nature of federal preemption provisions relating to employers' welfare benefit plans, including health plans. Relevant federal legislation is described below.

Congress enacted the Employee Retirement Income Security Act (ERISA) (29 U.S.C. Sec. 1001 et seq.) in 1974 to protect workers' pension and welfare plan rights by creating a single set of federal standards enforced by the Department of Labor and the Internal Revenue Service. ERISA includes provisions requiring disclosure of information about pension and welfare plans, setting standards of conduct for plan fiduciaries, including fair claims processing, establishing standards for vesting and funding (for pensions but not welfare plans), and providing plan participants and beneficiaries remedies for violations, including access to the federal courts.

With certain specific exceptions, "employee welfare benefit plans" covered by ERISA include those established by an "employer" to provide medical benefits, "through the purchase of insurance or otherwise. . . ." (29 U.S.C. Sec. 1002(3)). "Employer" is defined to include an individual employer and "a group or association of employers acting for an employer" (Sec. 1005(5)). A group or association of employers may establish a single ERISA-covered plan where the group association can demonstrate that it is a "bona fide" group or association. The Department of Labor has indicated that this status is shown by examining,

among other things, who actually controls the association (i.e., that employer members make the important decisions), who actually controls the benefit program, when and why the association was formed, and what relationship existed among members before the plan began. Where several unrelated employers merely execute a trust document as a means to fund benefits and where no genuine organizational relationship exists among the employers, no bona fide group or association of employers will be deemed to exist for purposes of creating an employer welfare benefit plan (see, e.g., DOL Opinion No. 89-13, July 20, 1989).

ERISA contains several important provisions concerning its effect on state law. The general preemption provision preempts any state law that relates to employee benefit plans (Sec. 1144(a)). Another provision, however, the "savings clause," saves from preemption, among others, those state laws that "regulate insurance" (Sec. 1144(b)(2)(A)). Finally, the "deemer clause" provides that employee benefit plans covered by title I of ERISA are not to be "deemed" insurers or insurance companies for purposes of subjecting them to state insurance laws (Sec. 1144(b)(2)(B)). Thus, welfare benefit plans covered by ERISA are generally outside the reach of state insurance regulation if they are self-insured (i.e., have not provided benefits through insurance contract or policies).

In the late 1970s and early 1980s, several well-published insolvencies of self-insured so-called multiple employer trusts (METs) caused Congress to revisit the issue of preemption. These METs claimed to be "employer associations" sponsoring employee welfare plans and refused to submit to state insurance regulation, such as certificates of authority, reserve, contribution and surplus standards, mandated benefits, and premium tax laws. State regulators felt at a loss because they thought the language of ERISA appeared to protect these entities. However, although these entities may have appeared to comply with ERISA by, for example, filing an annual report Form 5500, ERISA does not require employee welfare plans to file for pre-approval nor does ERISA set funding requirements for welfare benefit plans as it does for pension plans. Thus, these entities tried to avoid important insurance safeguards traditionally enforced by state Departments of Insurance.

The Erlenborn Amendments

In an attempt to remedy this problem, Congress passed the 1983 Erlenborn Amendment to ERISA. Under the law, a MEWA was defined as "an employee welfare benefit plan or any other arrangement . . . offering . . . any benefit to the employees of two or more employers . . ." (collectively bargained plans and plans formed by rural electric cooperatives were exempted from the definition. A 1991 Amendment added rural telephone cooperative associations to the preemption list). Fully insured MEWAs (those in which all benefits are

guaranteed under a contract of insurance) must comply only with state laws concerning reserve and contribution requirements. In the case of all other MEWAs, they must comply with reserve and contribution requirements and any other insurance regulation not inconsistent with ERISA (e.g., states may not reduce or modify the fiduciary or reporting requirements imposed by ERISA). The Amendment also provided that the DOL was free to issue regulations concerning how non-fully insured MEWAs might seek an administrative exemption. To date, DOL has not issued regulations of this sort. However, DOL has provided opinion letters to interested individuals on various ERISA provisions and it has issued many such letters concerning the applicability of state regulation to particular MEWAs. The DOL consistently has stated that MEWAs are subject to at least some state oversight.

Thus, MEWAs that are also employee welfare benefit plans must meet all of the requirements of ERISA along with any insurance requirements a state wishes to impose, to the extent permitted by the MEWA provisions of ERISA. Our interviews revealed that as a practical matter, however, most states do not regulate fully insured MEWAs except to the extent the underwriting insurer must comply with appropriate insurance laws. However, many states claim that when uninsured MEWAs market contracts for employee medical benefits, they are engaging in insurance-company-like conduct that should be subjected to state financial standards and regulation of solvency, consumer protection laws, and the like. Note also that where individual employers provide benefits through MEWAs that are not themselves ERISA welfare benefit plans, the employers may create single employer welfare benefit plans covered by ERISA. Those offering or operating MEWAs may also be subject to ERISA's rules governing fiduciaries and parties in interest.

Interpretations of ERISA and the Erlenborn Amendment

Language in the 1983 Amendment to ERISA subjects all MEWAs to state regulation of some sort. However, sponsors of uninsured MEWAs continue to claim preemption to insurance laws under ERISA. One state Department of Insurance official described a MEWA's typical response when investigated by the Department: It claims to represent a "bona fide employers association." Because ERISA defines "employer" to include "employer associations," the entity claimed to represent a single "employer" under this definition and not "two or more employers" under the definition of MEWAs set out in the Amendment. Thus the MEWA claims not to be a MEWA at all, but a single employer welfare plan exempt from state regulation (see 29 U.S.C. Sec. 1005(5)). Other MEWA sponsors may claim to be collectively bargained plans but are unable to demonstrate this status. Several courts and

the DOL have rejected overly clever arguments like this, but Departments of Insurance often must challenge these interpretations through expensive and time-consuming litigation.

Although recent coordinated efforts by DOL and the National Association of Insurance Commissioners (NAIC) have improved Insurance Departments' knowledge about MEWAs and their regulatory power over them, a surprising number of officials we interviewed held inaccurate or incomplete beliefs about ERISA and their ability to regulate MEWAs. Common mistakes included a perception that fully insured MEWAs were exempt from state regulation and that MEWAs could seek preemption from all insurance regulation through a request to the Department of Labor. Some states questioned their ability to regulate MEWAs in the absence of specific regulations promulgated by the state. At least one recent case, the National Business Association Trust (NBAT) decision, held that MEWAs were subject to state oversight even in the absence of specific legislation addressing them; other courts have offered conflicting opinions. Many states still believe that some preemption claims might have legitimacy; understaffed offices simply did not have the time to test every claim. However, it is important to note that these misperceptions declined over the time period in which we conducted our interviews. Federal efforts to educate and involve state officials in regulating MEWAs appear to have worked to increase state oversight and enforcement.

STATE APPROACHES TO REGULATING MEWAs

To fully understand the relationship between MEWA behavior and regulation, we conducted telephone interviews with officials in 18 Departments of Insurance chosen as representative of the various approaches states use to deal with MEWAs.¹ Strategies for dealing with MEWAs vary widely among the states, from virtually no preemptive regulation (other than attacking overt fraud or potential insolvency), to imposing only registration requirements, all the way to complete and complex pre-approval, financial standards, and monitoring. Several states mentioned that MEWA laws were pending or proposed in the state legislature.

As will become evident below, the relationship between regulation and behavior is complex. For example, the extent of formal MEWA legislation did not necessarily correlate with the level of success in preventing insolvencies. Similarly, in some cases, MEWAs may

¹The 18 states were California, Connecticut, Delaware, Florida, Georgia, Illinois, Michigan, Massachusetts, Missouri, New York, North Carolina, Oklahoma, Oregon, Rhode Island, Texas, Utah, Virginia, and Washington.

flourish even in states where an aggressive and well-funded MEWA fraud unit may operate. (There exists a cause-and-effect question here, of course; lax laws may have inspired MEWA development which then instigated increased oversight.) It also appears that with regard to areas where MEWA promoters choose to locate or avoid, market factors may be as strong an influence—or a stronger one—than a particular state's approach to regulation. For example, states that have a large number of non-unionized small businesses with limited affordable insurance options appear attractive to MEWAs. Some patterns did emerge, however, and these are described below. These approaches are described from most to least comprehensive, though, as set out below, lack of an explicit law did not necessarily inhibit states from actively prosecuting uninsured MEWAs.

NAIC's "Jurisdiction To Determine Jurisdiction Act"

In an attempt to address the states' continuing problem of countering improper claims of ERISA preemption, the National Association of Insurance Commissioners developed in 1982 a model act entitled "The Jurisdiction to Determine Jurisdiction of Providers of Health Care Benefits Act." In essence, the model act states that all providers of health care benefits are presumed to be subject to state insurance department jurisdiction unless they provide the department with some certificate, license, or other document by another governmental agency that permits or qualifies it to provide those services. Any other claims of preemption will fail; all such entities are subject to examination and must disclose their status as less than fully insured to prospective purchasers. Approximately 25 states have adopted this provision or some law similar to it.

Regulators in states that use the NAIC Act to attack uninsured MEWAs as "unauthorized insurance" point to its major limitation: These entities claim to be exempt from all insurance regulation under ERISA, despite the "presumption" language. For the most part, these entities do not voluntarily approach departments but are only identified when disgruntled policyholders complain that the MEWA fails to pay claims or when agents call with concerns about "low ball" rate quotes. Nonetheless, some states use the act to demonstrate their authority over these entities.

Comprehensive Legislation Concerning MEWAs

Michigan, Florida, and Virginia have passed comprehensive laws intended to monitor and manage uninsured MEWAs. Each has had a markedly different experience under these laws. (At least two other states, South Carolina and Minnesota, also allow for licensing of uninsured MEWAs that meet prescribed standards.)

Michigan. Michigan passed comprehensive MEWA regulations in 1986, in response to a large local insolvency in the early 1980s. The state legislature considered outlawing all uninsured MEWAs, but local TPAs with long-standing MEWA business lobbied successfully for more stringent regulation instead. (Like most other states, described below, Michigan does not regulate fully insured MEWAs separately; regulators believe that standard insurance law adequately protects consumers from abuses by these entities.)

The law imposes requirements on uninsured MEWAs that mirror those placed on insurance companies as well as adding several new provisions unique to MEWAs; it applies to both domestic MEWAs and those "soliciting an employer domiciled in Michigan" (Michigan Ins. Laws Sec. 500.7001, et seq.). Michigan has not experienced a domestic MEWA insolvency since the law was passed in 1986.

Before uninsured MEWAs may solicit business, they must apply for a certificate of authority, post bond, and demonstrate financial viability. MEWAs must be sponsored by a nonprofit association of employers or employees that has existed for at least two years with some purpose other than the provision of insurance to members. To assure an adequate "critical mass" to support the plan, the association must consist of at least five members with a total of 200 policyholders and annual gross premiums of at least \$200,000. Other provisions in the law prevent conflicts of interest by its employer trustees, assure adequate internal administration or (as is the case for most Michigan MEWAs) a contract with a TPA, and require annual reports and examinations to assure continuing financial viability. Interestingly, Michigan requires these MEWAs to acquire stop-loss insurance at a \$25,000-per-occurrence basis; aggregate stop-loss is optional. Regulators there believe that stop-loss limits, which can be upward of \$1 million, are often useless because most MEWAs will be bankrupt before the limit is met.

Reserve and surplus standards are also specified: the greater of 25 percent of aggregate premium contributions for the current fiscal year or 35 percent of paid claims in the year. Reserves may not fall below 2-1/2 months of yearly premiums or the MEWA must assess its policyholders an extra month's premium. This provision has been invoked several times, but in a flexible manner that allows plans to spread the additional cost over several months. The law also allows the state's Department of Insurance to assess MEWAs to fund a special guarantee fund for insolvent MEWAs but it has never had to invoke this provision. Regulators believed that these MEWAs tended to offer competitive premiums, though not extremely low ones.

Only about 20 MEWAs are regulated under this scheme, which may explain some of its success. Like other Midwestern states, a large percentage of Michigan's population is

unionized and covered through comprehensive collectively bargained plans so that MEWAs have fewer market opportunities in the state. Although regulators had encountered out-of-state MEWAs attempting to market in Michigan, they had been able to encourage several to become fully insured. State officials seem justifiably proud that the law has succeeded in keeping the MEWA option available to small employer-members of trade associations.

Florida. Despite its comprehensive regulatory framework, Florida has had less success in assuring solvency of its licensed, uninsured MEWAs. Some of its standards parallel Michigan's, including allowing only bona fide nonprofit associations to sponsor MEWAs. However, at the time we spoke with state regulators, only five of the 28 plans that Florida had approved under the law remained functioning and three of those were running deficits. All others became insolvent and voluntarily dissolved or were forced into receivership by the state's Department of Insurance .

Florida's law differs from Michigan's in several important ways. Most significantly, until very recently, the scheme did not set specific reserving and rating guidelines for MEWAs to follow. Instead, MEWAs needed only to seek "professional actuarial guidance" in setting reserves and pricing the product. Even stop-loss coverage was determined by an actuary's report. MEWAs needed these reports only once every three years. Florida recently changed its law to allow for assessments of MEWAs to fund claims for those that become insolvent and also to set reserve standards. Currently, the law requires that three months of premiums must be set aside.

The regulator interviewed listed the following reasons for the large number of uninsured MEWA failures in his state, despite this special regulatory scheme: poor rating practices, inadequate or nonexistent capitalization, lack of underwriting, poor financial and claims management, poor reporting, and inadequate cost control and utilization review programs. Some of these problems may be remedied by recent amendments to the MEWA law in Florida.

During the course of our interviews, Florida often was named as the site of many troublesome MEWAs that market in other states—uninsured MEWAs that apparently had not bothered to become licensed under Florida's laws. Regulators in Florida have investigated seven uninsured/unlicensed MEWAs, and eight questionable associate union plans, and estimate that as many as 80–100 self-funded employee leasing firms exist there. Like some other states where MEWAs tend to solicit business, Florida has a large nonunionized workforce that is dominated by small employers. Small employers have faced steep premium increases in recent years and turn to MEWAs as a last resort. Perhaps because of problems both with licensed and unlicensed MEWAs, Florida Insurance

Department officials have played a leadership role in promoting aggressive enforcement policies against MEWAs that attempt to avoid proper regulation.

When trying to understand the source of Florida's reputation for harboring many uninsured MEWAs, it is difficult to sort out the effects of demographics from those of the weak MEWA licensing law, especially because so many MEWAs simply claim preemption from the regulatory procedure to begin with. It is also difficult to measure whether the aggressive stance of the Department of Insurance reflects post hoc efforts to control the state's difficulties or whether MEWAs have been able to proliferate there despite these efforts. It is clear, however, that Florida's attempt to legalize uninsured MEWAs offers a case study of the danger of comprehensive schemes that fail to address the worst practices of uninsured MEWAs—underreserving and poor rating practices.

Virginia. Most recently, Virginia passed a new law intended to address problems posed by uninsured MEWAs. These regulations require that all MEWAs apply for state licensure before marketing health coverage in the state. To attain a license, the regulations state that each MEWA must provide a security deposit, maintain a defined minimum surplus and the same level of reserves insurers must maintain, provide evidence of "risk-sharing agreements," and be subject to assessment. The plans must also meet certain other administrative and fiduciary duties and must meet state mandate requirements. If the plan is not fully insured, it must reveal this to potential policyholders.

This regulatory scheme applies to all MEWAs but also contains a provision that allows fully insured MEWAs to apply for preemption from the statute if they demonstrate their fully insured status. (Like other states, Virginia regulates fully insured MEWAs only to the extent the underlying insurance company is regulated.) Thus far, Virginia regulators have been inundated with applications for preemption—550 by the time we spoke with them. Regulators explained that this surprisingly high number may simply be a result of the large number of trade associations headquartered in the Washington, D.C., area that sponsor fully insured health plans for members. Only three plans attempted to get licensed, all without success. Two failed to meet the stringent financial standards and one out-of-state MEWA would violate its charter to market in Virginia. There was a general sense that most uninsured MEWAs could not meet the stringent financial standards imposed by the new law.

At the time of our interview, Virginia had instituted court proceedings against three uninsured MEWAs that failed to apply for licensure. Regulators had opened files on 130 other questionable "entities," though it was difficult to say whether these would end up as challenges as well. One regulator reported on a MEWA that another state successfully shut down. The individuals sponsoring that MEWA came to Virginia (and purportedly 10 other

states) and tried to set up another MEWA—claiming ERISA preemption from state regulation. The “pseudo-association” sponsoring the MEWA, the TPA, and the trustee were all so closely related (i.e., employees of each other) that numerous ERISA fiduciary conflict-of-interest requirements and prohibited transaction provisions would have been violated. Virginia is challenging this plan in court.

So far, the only positive effect of Virginia’s extensive regulation is an unexpected one—a count of that state’s insured MEWA population. The preemption rush placed a major burden on the two-member MEWA staff, which is attempting to streamline the process by issuing regulations that automatically exempt “group-type plans”—those in which the insurance contract runs directly to the insured rather than to the association. Regulators there believe there is less opportunity for abuse and more consumer protection where an association does not hold the contract directly.

As elsewhere, most uninsured MEWAs have remained “underground” and those that have surfaced to apply for licensure have been unable to meet financial standards that the state believes are necessary to assure viable enterprises.

State Registration Laws

Several states, alone or in conjunction with other regulations, require all MEWAs to register before they may market in that state. The success of these efforts has been mixed. In North Carolina (described below), the law required registration by all MEWAs within 60 days of passage in August 1990. At the time of our interview, no MEWAs had registered. In Virginia, described above, the registration requirements are in conjunction with complete regulatory schemes. (At least one other state, Arkansas, also has a registration requirement.) Regulators stated that, for the most part, fully insured MEWAs comply with the requirements but that uninsured MEWAs continue to claim ERISA preemption even from simple registration requirements.

Still, more than one official told us that their states are also considering imposing registration requirements on all MEWAs in an effort to get a handle on the extent of the problem and to have some way of monitoring these entities. The track record for forcing compliance from uninsured MEWAs, however, has not been good.

Laws Regulating Third Party Administrators

Several states have passed, or may soon propose, legislation regulating TPAs as one means of attacking the MEWA problem. Some regulators believe that TPAs administer most MEWA business, though opinions differed as to whether most of these MEWAs were poorly

run. The TPA regulations in Illinois, for example, impose requirements including reporting on MEWA and association business, separate accounting for each client, reserving and financial standards and conflict of interest prohibitions.

Although these schemes are too new to judge, regulators seem confident they may be one means of indirect attack on MEWAs. This effort may be curtailed somewhat by a circuit federal appellate case that found that ERISA preempts TPA statutes to the extent they affect self-insured plans (*Gallego v. SIIA*). However, states may still regulate fully insured business and it seems likely that, with the language of the Erlenborn Amendment, states can also impose standards on a TPA's MEWA-related business.

Regulation of Brokers Who Sell MEWA Products

Several state departments of insurance have used their licensing authority over insurance agents and brokers as a tool to prevent the marketing of uninsured MEWAs. Utah passed a law that explicitly prohibits agents from selling "unauthorized METS" (read: uninsured MEWAs). Utah may revoke the license or impose fines or other sanctions on a broker found to be selling uninsured MEWA products. Utah and several other state insurance departments issue bulletins to agents reminding them of their liability under state law for unpaid claims when they sell "unauthorized insurance" that becomes insolvent. Regulators report that they have received many tips leading to investigations of uninsured MEWAs resulting from this publicity. Some states actually prosecute agents, and others agree that agents often remain ignorant of MEWAs' actual status under ERISA, and their claims of preemption from state regulation. Until brokers become better informed, the bulletins serve the primary function of helping insurance department officials identify unlicensed MEWAs.

However, we have also learned about a possible weakness in this approach. Several insurance agents and brokers we spoke with told us that although they still receive direct mail solicitations from MEWAs, they rarely receive telephone calls or visits from MEWA representatives. Apparently, some operators are approaching clients directly. In one variation, MEWA administrators set up a supposed association for a particular industry and approach employers with what they claim is a tailor made health plan (i.e., "The Flower Growers Health Benefit Trust"). Agents say that they are being more cautious about selling these plans, but if MEWAs are approaching employers directly, disciplining agents and brokers will have no effect.

Uninsured MEWAs as Unauthorized Insurance

Other than the NAIC Model Act, the vast majority of the states had no special legislation aimed at regulating uninsured MEWAs. Instead, insurance department officials attack them under state laws prohibiting the sale of "unauthorized insurance"—companies selling products that indemnify for health benefits but which have not sought to meet state requirements necessary before a certificate of authority is issued. Regulators admitted, however, that this approach has its weaknesses. The major concern, of course, was that some MEWA operators either ignored this position or sincerely believed that somehow they were exempt from ERISA. Without prior identification, officials cannot attack these entities until they receive complaints about nonpayment of claims or questions from agents concerned about underpriced products.

Even when the uninsured MEWAs are finally identified, regulators claim that they still face significant obstacles in asserting state jurisdiction over these entities despite existence of the NAIC Model Jurisdiction Act. For example, some officials who have attempted to obtain "cease and desist" injunctions from courts point out a problem with this remedy: Regulators must demonstrate the potential for "irreparable harm." This can be shown only by potential or actual insolvency of the MEWA—and at that point no funds exist to pay outstanding claims. Because MEWA performance is not reviewed regularly, state action is often too late.

In any event, litigation is time-consuming and expensive and requires educating courts about the intricacies of ERISA and its complex preemption provisions. Many understaffed insurance department offices try instead to find alternatives to going to court. Frequently, officials hold informal talks with sponsors of uninsured MEWAs and attempt to convince them to seek insurance or at least to leave their states. In some cases, MEWAs have agreed to become insured. More frequently, however, marginal MEWAs may agree to leave the state if litigation is threatened. One regulator confessed that, in the interest of protecting residents of his state, his office agreed not to do anything to jeopardize one MEWA's ability to make a preemption claim in another state so long as the MEWA left his state. This "every state for itself" attitude appears to be waning as federal and state regulators begin to coordinate attacks on interstate MEWAs. But it does point out the problems insurance departments continue to face despite the clarifying language of the Erlenborn Amendment and the NAIC Model Act concerning state regulatory authority over MEWAs.

Only One State Allowed Uninsured MEWAs To Market

When initially interviewed, regulators in North Carolina explained that there, uninsured MEWAs could market their products, so long as they disclose their uninsured status to potential purchasers. (Until more recently, other states held similar positions de facto by not actively intervening.) This state would not pursue agents for claims if these MEWAs became insolvent so long as this disclosure occurred, although the office did attack fraud and attempted to insist that marginal MEWAs improve their financial status. The regulator interviewed believed that better regulated uninsured MEWAs might help solve the problems small employers face finding affordable health care plans.

The regulator interviewed stated his belief that most MEWAs came into North Carolina from out of the state. (Indeed, of the four ongoing MEWA insolvencies in North Carolina at the time of the interview, only one was based in the state.) However, interviewees from many states identified North Carolina as the home of many MEWAs that had crossed borders to market in their states. Its lenient "disclosure" position appears to have encouraged uninsured MEWA development. However, we also learned that, in the face of recurring problems with these entities, North Carolina regulators now ban uninsured MEWAs.

Most States Do Not Separately Regulate Fully Insured MEWAs

Most states have not passed special laws (except for registration in several cases) regulating fully insured MEWAs. Insurance department officials rationalized this by pointing out that the insurance company that underwrites the MEWA must meet the capital, reserve, reporting, consumer protection, guarantee fund contribution, and other laws imposed on them to do business in their states.

This rationale fails to consider potential abuses by those MEWAs insured by marginally solvent insurance companies or problems when a MEWA creates a pseudo-association for marketing purposes only. In addition, finding and regulating marginally solvent insurers extends beyond just regulating MEWAs. Several regulators view these problems as part of the bigger issue of abuse of the "group" label by insurers and the apparent ability to avoid stringent state regulation by incorporating or setting up trusts in states with less extensive regulation and marketing across state lines.

Some states such as Oregon are taking steps to address this "group" label problem with special legislation aimed at assuring that only "bona fide associations or trusts" (read: insurance company MEWAs) may market in their states (Oregon Laws 1989, Chapter 784). Uninsured plans are considered "unauthorized insurance" and banned in Oregon. An

association is "bona fide" only where active employer oversight exists to prevent abuse and where the association was not created solely to get insurance. Trust arrangements must cover one or more employers or unions in the same industry, apparently to assure that some kind of predictability and risk-spreading occurs. The law applies to both domestic and out-of-state insurers. The department looks with suspicion at plans in which the trustee, administrator, and marketing agent are all the same or related individuals or entities rather than the employer or association —a situation potentially inviting abuse. As of late in 1990, 75 insured association plans had registered with the department.

REGULATION AND MEWA "JURISDICTION SHOPPING"

Fully Insured MEWAs

Our interviews produced contradictory observations concerning how state regulation and enforcement efforts affect MEWA choices of states in which to domicile and in which to market. At the outset, in our interviews, regulators distinguished between uninsured (typically labeled "unauthorized") MEWAs and fully insured MEWAs.

Incorporation decisions of insured MEWAs appear to reflect the same factors considered by other insurance companies. First, some states, like Connecticut, require that any business done under the guise of a "trust" have the trust sited in the state, so a local business association starting a MEWA may have no choice of where to incorporate. More often, the choice is influenced by the stringency of a particular state's "group" insurance laws. States such as Missouri, Rhode Island, and Delaware, for example, have few (or no) requirements to be designated a "group" plan. Insurance companies may choose to incorporate there and then attempt to market these plans in other states, which sometimes accept the group designation without subjecting the company to their own requirements for group plans. This reciprocity policy was created to assist large multistate employers avoid duplicative regulation when one policy covered employees in several states.

Because regulators have begun to observe that some insurers have created artificial "organizations" specifically to benefit from the "group" designation, many states no longer accept every "group" designation as a matter of course. At the least, many require that the laws of the state of origin be as stringent as their own. Some now impose other state requirements, such as state mandated benefits, even on group plans domiciled elsewhere. However, regulators report that insurance companies still "jurisdiction shop" for favorable domiciles.

The existence or nonexistence of other types of insurance regulation also may affect an insurer's decision to establish its operations in a particular state. For example, financial

standards and reserving requirements are lower in Texas than in most other states. Also, Texas allows "trusts" created by two or more employers in "the same or similar industry" to qualify as "groups" under its law. A qualifying trust need not have its situs in Texas to qualify. However, Texas law does not grant jurisdiction over nonresident trustees. Not coincidentally, during interviews, regulators frequently named this state as a common home to MEWAs that ultimately end up in financial trouble. Paradoxically, regulators also note that this state has been particularly active and aggressive in pursuing sponsors of insolvent MEWAs. Thus, as described below, the existence of weak regulations does not necessarily correlate with a less-aggressive enforcement stance by insurance departments. However, several active insurance department officials complained about the relatively weak legislation they felt inhibited some of their power to attack marginal MEWAs.

Uninsured MEWAs

The issue of the effects of regulation on uninsured MEWA marketing decisions is even more complex. Because most uninsured MEWAs attempt to escape state regulation altogether, incentives for incorporating in particular states may differ from the careful calculations made by insurance companies sponsoring MEWAs. Indeed, those states listed by regulators in interviews as common homes of uninsured MEWAs—Texas, California, Florida, North Carolina, and others—did not necessarily correlate with those where insured MEWAs tended to incorporate—Rhode Island, Delaware, and Missouri.

Regulators listed a number of states that appear to house many uninsured MEWAs. These states varied both in their general approach to insurance regulation (capitalization/reserves/mandates) and in their reputation as aggressive in pursuing sponsors of uninsured MEWAs. Texas, for example, has more relaxed standards for establishing an insurance company but also has a reputation for aggressively attacking and closing down uninsured MEWAs. California, on the other hand, has stringent standards to establish insurance companies but got mixed reviews from other regulators in its willingness to aggressively pursue uninsured MEWAs. Finally, regulators listed several other states, such as Missouri and North Carolina, as generally lax in allowing plans to market and only recently becoming interested in attacking them in any organized manner.

Parenthetically, it may be true that some of the more aggressive states became so only recently in reaction to problems faced by residents as a result of insolvent MEWAs. However, it appears that MEWA activity has increased in these states, even in recent years, so that an insurance department's reputation for seeking out uninsured MEWAs may have little effect on sponsors' decisions concerning where to market their product. It may also be

the case that some states appear to be havens for legitimate MEWAs despite the fact that they have been more aggressive in identifying and attacking uninsured MEWAs.

In general, MEWA proprietors look to business economics more than lax regulation in determining where to market. Each state identified as having large numbers of MEWAs has a large potential market of non-unionized small employers without affordable insurance options. For example, fewer problems were reported by regulators in states with smaller populations, in states with heavily unionized labor forces, and in those with larger employers. Although sponsors of some uninsured MEWAs may factor in the regulatory climate when considering where to market, it seems that opportunities for profit may be a more important incentive.

Interstate Movement and Regulatory "Extraterritoriality"

One interesting historical note provided by a state official shed some light on why insurance companies first initiated the "trust" form for marketing health insurance to small groups. Insurance companies set up trusts in states with relatively lenient regulation, using local financial institutions as trustees. They then cross over into other states and use local agents to market memberships in these "trusts" rather than marketing small employer or "franchise" insurance. Insurance companies hoped to use the trust device to avoid the special regulation imposed on "franchise" insurance. Another regulator described a recent attempt by an agent to market a nonresident trust. Because his state requires (1) that all policies for health insurance be approved by his office before they can be marketed; and (2) that any entity doing business as a trust must be domiciled in the state, his office prosecuted the agent selling the trust business. He believes this set a good example that will help prevent manipulations of this sort.

Several regulators mentioned another common tactic used by MEWAs to avoid state oversight. A MEWA may "set up shop" in one state but then do most of its business in other states in an attempt to avoid attracting the attention of its home state's insurance department. MEWAs that conduct business this way may feel they can exploit state regulators' inability or hesitance to assert jurisdiction over nonresident MEWAs. Although some states have passed laws asserting authority to attack out-of-state entities that market "unauthorized insurance," others have limited authority over these MEWAs. For example, one regulator noted that its laws allow the insurance department to seek insolvency proceedings only against resident insurance companies. Some laws prevent regulators from attacking "trustees" that are not located in the state. Other regulators opined that they can

barely keep up with demands made by resident insurance companies much less deal with entities crossing state lines.

One successful solution attempted is improved coordination among state and federal officials in tracking uninsured MEWAs. When officials learn about a potentially insolvent MEWA, they may contact the insurance department of the MEWA's home state to attempt a coordinated response. Several active investigations and prosecutions have resulted from coordinated responses such as these. Regulators especially praised efforts that included involvement by the Department of Labor—audits of annual reports (Form 5500) and other actions to close down questionable entities.

MEWAs and State Health Insurance Guarantee Funds

A related issue concerns access to state guarantee funds by policyholders of insolvent MEWAs. Uniformly, regulators stated that claimants against uninsured MEWAs that become insolvent had no access to these funds, either because these MEWAs were labeled "unauthorized insurance" or because a law existed specifically precluding participation by uninsured MEWAs. Officials tended to support this policy because these MEWAs fail to pay premium taxes and assessments that contribute to guarantee funds. Indeed, lack of this safety net (along with others such as conversion rights and consumer protections) was a primary reason why many state regulators feel uninsured MEWAs should be illegal.

In contrast, claimants against fully insured MEWAs are allowed access to these funds. Most states limit access to state residents only, and allow payments only where the MEWA was resident in the state when it became insolvent. However, regulators offered three variations: (1) where the insurer has ever been licensed in the state (even if it is not currently a resident) the fund will pay the unpaid claims; (2) a state agreed to pay nonresident claims left unpaid by a local insurer where that insurer attained their business without properly registering in the new state. Because of this, the insolvent insurer was "unauthorized" there and these out-of-staters were denied access to the fund in their own state; and (3) a state will pay out-of-state victims if the insurance company was licensed in that state.

REGULATION SUMMARY

Interviews with state regulators revealed enormous difficulty and complexity in efforts to regulate the mostly "underground" activities of uninsured MEWAs. Several general conclusions can be drawn, however:

- The only successful regulatory scheme that legalized uninsured MEWAs did so by treating them like insured entities, requiring reserving practices similar to (though less stringent than) those imposed on insurers.
- MEWA entrepreneurs seek markets where potential customers live—states with many non-unionized small employers who cannot afford the high cost of regular health insurance.
- No clear relationship exists between the stringency of existing law, the aggressiveness of particular insurance departments, and the likelihood that a state will experience numerous MEWA insolvencies.
- Some states may appear to have more problems simply because they are better at ferreting out troublesome MEWAs. However, MEWAs may choose some situs because “front end” regulation (i.e., licensure and other qualifications) is lax, even if the fraud unit of the department is known as particularly aggressive.
- Regulators generally do not target insured entities, despite the common tactic of MEWAs to create “pseudo-associations” as a means of marketing their products.
- Uninsured MEWAs failed to comply with registration requirements of those states in which we interviewed.
- Finally, it became *eminently clear* during the time we conducted these interviews that state insurance departments are becoming increasingly aware and sophisticated in attacking these entities. Many attributed this to efforts by the Department of Labor to educate and involve them in attacking interstate operations.

5. POLICY IMPLICATIONS

MEWAs have arisen as a response to small firms' demand for health coverage at a lower price than conventional insurers currently make available. However, the ways in which MEWAs are making their product more affordable invite potential abuses. By claiming preemption from state regulation, MEWAs can provide health coverage at a lower price. However, as a consequence of this lack of state regulation, they expose their participants to significant financial risk.

To fill a need for lower cost health coverage products, MEWAs have sought to emulate self-funded employer plans. However, our review of the underpinnings of the small group market suggests that the analogy is not exact. Many small groups cannot be combined to exactly duplicate the situation in a single large firm. The ability of small firms to opt in and out of the MEWA makes it inherently subject to risk selection that compromises the stability of the MEWA. Further, a MEWA has no other assets to draw upon if claims exceed reserves.

The avoidance of state reserve requirements and premium taxes has been a key element in allowing MEWAs to charge lower prices. Although state reserving requirements and premium taxes that support insurance guarantee pools do raise the cost of buying insurance, they also protect insurance buyers from the financial loss if an insurer has high levels of claims or becomes insolvent. The additional costs imposed by reserving represent a premium for the insurer's opportunity cost of tying up capital. MEWAs may offer their product at a lower premium, but they make the buyer assume more risk because the safety net features built in to state regulation are missing for MEWA policies. As is well known in financial markets, a price differential results from differences in the riskiness of the product sold.

Unfortunately, many small firms do not understand that they are bearing additional risk when they purchase a MEWA product, and some unscrupulous MEWAs have deliberately misrepresented the insurance status of their policies. This information gap should be eliminated so that consumers understand the character of the product they are buying from MEWAs. However, it appears that simply notifying potential consumers that they are buying a self-funded product is not sufficient. North Carolina, which has this regulation, has been the site of some notable MEWA failures.

Our results raise a question of whether uninsured MEWAs can be viable in any circumstances. State experience suggests that registration and disclosure of uninsured status are not sufficient. Requiring MEWAs to maintain reserve levels similar to those of

insurance companies appears to improve their financial stability. The experience in Michigan suggests that when MEWAs are regulated in a manner similar to conventional insurance, MEWAs complying with such regulation can provide a financially stable, lower cost source of health coverage. Unfortunately, since MEWAs do engage in jurisdiction shopping, unscrupulous operators may simply avoid stringent reserve requirements by moving their operations to another state. Thus a state may reduce MEWA failures within the state by imposing stiffer reserve requirements, but these regulations will not stop MEWAs from operating in other states.

The observation that MEWAs are stable when they are subject to reserving requirements and premium taxes suggests that MEWAs should be treated more like conventional insurance companies. There is also an argument that insurance companies should be more like MEWAs in certain respects. One cost-saving feature of MEWAs is the ability to sell coverage that does not cover all the benefits mandated by state law. Clearly these "bare bones" products have filled a niche in the health coverage market. The marketing success of MEWAs suggests that consumers would like to have available a lower-cost product with narrower scope.

Some MEWAs have engaged in fraud. Clearly, this type of criminal behavior has no place in the market. However, many MEWAs are legitimate, and their failures result from ill-advised business practices, which were not adequately constrained by state regulation. MEWAs do fill a niche in the market by providing lower-cost health coverage. Policymakers are now deciding how to make lower-cost health coverage available to all workers. Requiring MEWAs to operate under constraints similar to those faced by conventional insurance companies and eliminating state mandate requirements for state-regulated insurers are two alternatives for achieving this goal.

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